

## **PNEUMOCOCCAL**

8/15/1997

## PNEUMOCOCCAL POLYSACCHARIDE VACCINE ADMINISTRATION REQUEST

"I have received the Pneumococcal Polysaccharide Vaccine (2001-2002) What you need to know before you or your child gets the vaccine statement sheet, and have read or have had explained to me the information in this sheet about Influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Influenza vaccine and ask that it be given to me or the person named below for whom I am authorized to make this request"

Clinic		County							
Information about person to receive vaccine ( please prin								For Clinic Use Only:	
NAME:	LAST FIRST MIDDLE INITIAL				BIRTHDATE AGE			CLINIC / OFFICE ADDRESS:	
								DATE VACCINE ADMINISTERED:	
								VACCINE MANUFACTURER:	
ADDRESS:	STREET		CITY	COUNTY	STATE		ZIP	VACCINE LOT NUMBER:	
								SITE OF INJECTION:	
								SIGNATURE OF VACCINE ADMINISTRATOR:	
	SIGNATURE OF I	PERSON TO RECEIVE OF	R PERSON AUTHORIZED	TO MAKE THE I	REQUEST:			X	
								TITLE OF VACCINE ADMINISTRATOR:	
1 X	DATE								
	Informat	tion about person t	o receive vaccine	( please prin	ıt ).			For Clinic Use Only:	
NAME:	LAST	FIRST	MIDDLE	INITIAL	BIRTHD	ATE	AGE	CLINIC / OFFICE ADDRESS:	
								DATE VACCINE ADMINISTERED:	
								VACCINE MANUFACTURER:	
ADDRESS:	STREET		CITY	COUNTY	STATE		ZIP	VACCINE LOT NUMBER:	
								SITE OF INJECTION:	
								SIGNATURE OF VACCINE ADMINISTRATOR:	
	SIGNATURE OF I	PERSON TO RECEIVE OF	R PERSON AUTHORIZED	TO MAKE THE F	REQUEST:			X	
								TITLE OF VACCINE ADMINISTRATOR:	
2 X	DATE								
	Informa	tion about person t	o receive vaccine	( please prin			Ī	For Clinic Use Only:	
NAME:	LAST	FIRST	MIDDLE	INITIAL	BIRTHD	ATE	AGE	CLINIC / OFFICE ADDRESS:	
								DATE VACCINE ADMINISTERED:	
				1				VACCINE MANUFACTURER:	
ADDRESS:	STREET		CITY	COUNTY	STATE		ZIP	VACCINE LOT NUMBER:	
								SITE OF INJECTION:	
								SIGNATURE OF VACCINE ADMINISTRATOR:	
	SIGNATURE OF PERSON TO RECEIVE OR PERSON AUTHORIZED TO MAKE THE REQUEST:							X	
3 X					DATE			TITLE OF VACCINE ADMINISTRATOR:	
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NAME		formation about person to receive vaccine ( please pri			1			For Clinic Use Only:	
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								DATE VACCINE ADMINISTERED:	
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ADDRESS:	STREET		CITY	COUNTY	STATE		ZIP	VACCINE LOT NUMBER: SITE OF INJECTION:	
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	SIGNATURE OF I	PERSON TO RECEIVE OF	R PERSON AUTHORIZED	TO MAKE THE	REQUEST.			X	
4 X					DATE			TITLE OF VACCINE ADMINISTRATOR:	
Information about person to receive vaccine ( please print ).							For Clinic Use Only:		
NAME:	LAST	FIRST	MIDDLE		BIRTHD	ATF	AGE	CLINIC / OFFICE ADDRESS:	
								DATE VACCINE ADMINISTERED:	
								VACCINE MANUFACTURER:	
ADDRESS:	STREET		CITY	COUNTY	STATE		ZIP	VACCINE IOT NUMBER:	
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1								SIGNATURE OF VACCINE ADMINISTRATOR:	
	SIGNATURE OF	PERSON TO RECEIVE OF	R PERSON ALITHORIZED	TO MAKE THE	REQUEST:			X	
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